DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

E Washington/CO

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 02 — 22
2. STATE: Michigan

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
March 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 435.310

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ (40.3 million)
b. FFY 2004 $ (69.2 million)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 2.2-A page 26

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 2.2-A page 26

10. SUBJECT OF AMENDMENT:
eliminate coverage of care taker relatives

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
James K. Haveman, Jr.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
James K. Haveman, Jr.

14. TITLE:
Director

15. DATE SUBMITTED: 12/20/2002

16. RETURN TO:
Michigan Department of Community Health
Capitol Commons Center - 7th Floor
400 South Pine
Lansing, Michigan 48933

ATTN: Nancy Bishop, Policy and Federal Affairs

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/23/02

18. DATE APPROVED: February 10, 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
3-1-03

20. SIGNATURE OF REGIONAL OFFICIAL:
Minnie Hood-Griffin, Acting ARA

21. TYPED NAME:
Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
DEC 23 2002
DMCH - MI/MN/WI

FORM HCFA-179 (07-92)

Instructions on Back

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
Medical Services Administration

MEMORANDUM

To: Nancy Bishop

Date: December 19, 2002

From: Robert Stampfly
Director, Policy and Legislative Support Division

Re: State Plan Amendment

Attached are your copies of the State Plan amendment. Information specific to the plan amendment is as follows:

1. Effective date of plan change:
   March 1, 2003

2. CFR citation under which proposed change is to be made:

   42 CFR 435.310

3. Plan material submitted:

   Attachment 2.2-A, page 26

4. Plan material superseded:

   Attachment 2.2-A, page 26

5. Purpose of amendment:

   To eliminate coverage of the optional group of caretaker relatives.

6. Summary of change from current plan:

   Current plan provides for coverage of the optional group of caretaker relatives.

7. Federal Budget Impact:

   a. FFY 2003 $ (40.3 MILLION) b. FFY 2004 $ (69.2 MILLION)

8. FOR INSTITUTIONS ONLY: Is the change significant?

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

Groups Covered

C. Optional Coverage for the Medically Needy (Continued)

MDCH	42CFR 435.310	__	6.	Caretaker Relatives
MDCH	42CFR 435.320 and 42CFR 435.330	X	7.	Aged Individuals
MDCH	42CFR 435.322 and 42CFR 435.330	X	8.	Blind Individuals
MDCH	42CFR 435.324 and 42CFR 435.330	X	9.	Disabled Individuals
	42CFR 435.326		10.	Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.
	42CFR 435.340		11.	Blind and disabled individuals who:

a. Meet all current requirements f or Medicaid eligibility except the blindness or disability criteria;

b. Were eligible as-medically needy in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.